Essential Health Benefits Work Group
Thursday August 30, 2012
8:00am – Meeting Minutes
Brown's Continuing Education Building

Attendees: Kathryn Shanley, Commissioner Koller, Deb Faulkner, Gary Witman, Bonnie Smith, Susan Yolen, Mark Kerrin, Cathy Ciano, Jason Brown, Elaine Jones, Elaina Goldstein, Elizabeth Lange, Bill Hollinshead, Mark Deion, Paul Block, Owen Heleen, Chris Asura, Mike Ryan, Amanda Clarke, Kim Holloway, Joshua Greenberg, Dawn Wardyga, Vivian Weissman, Amy Black, Tim Bonin, David Keller, Brian Jordan, Betsy Loucks, Terrie Martiesian, Tara Townsend

I. Call to Order – Lindsay McAllister, Office of the Lt. Governor, called the meeting to order at 8:00am. She thanked everyone for his or her time over the course of the past few months and noted that this is the wrap up of the public stakeholder process for the Essential Health Benefits Work Group. Today we will go back briefly over the work we have done these past few months, and also discuss the comments we have received during the public comment process these past few weeks.

II. Presentation: Slides available on website and upon request by emailing llapolla@ltgov.state.ri.us

Questions/Comments/Concerns:

a. Mark Deion: When you get to the end of this, and you come to the conclusions that the EHB may not necessarily be affordable, who will come back to the table and ensure that it is affordable? If this results in being just as expensive or more expensive, who will come back to the table to pare it out?
    i. Lindsay McAllister: There are two approaches. First, this designation counts for 2014 and 2015, and as soon as a designation is made the data is going to CMS and HHS. We do not know how this process will work beyond 2015, if it will be punted back to the states or if the federal government will make adjustments. We chose these lists of services, and then there will be a discussion of plan design and administration amongst the Exchange, and the Office of the Health Insurance Commissioner.
b. Elizabeth Lange: The other two columns then administrative etc. will be overseen by the Exchange work group and the Exchange director?
    i. Lindsay McAllister: Yes.
    ii. Commissioner Koller: It is not like there is a future decision. On the benefit design column, the exchange will have the ability to decide what the terms and conditions are for accessing the benefits. If this is the list, and we find we need to make it more affordable, the Exchange can work with the plans at that point through certain dialogues. That is for the people through the

exchange, of the rest of the market, which will not change from the process we have now. Insurers will have plans, and employers decide if they would like to buy them. Benefit administration, we have a set of rules that are there, how health plans make medical necessity determinations, what rights consumers have to appeal those. There are laws in RI already governing these things.

iii. Elizabeth Lange: Would it be then that benefit design would be set by the insurer, it would be governed by the body you described, and negotiations would go from there?

iv. Commissioner Koller: Yes, but on the exchange the dialogue would be between the insurers and the exchange. That is the whole Qualified Health Plan discussion. The exchange is trying to figure out how directive it would like to be with setting the terms and conditions of coverage. The idea is that it would be more standardized than it is now.

c. Commissioner Koller: To my office, to the extent these comments are more applicable to conversation than enforcement and are applicable in our environment, we will also take into account these comments.

d. Elaina Goldstein: The first comment about arbitrary limits, and the last comments about parity, I think part of the issue, at least about habillitative benefits, is that nay number of visits is an arbitrary limit. Are you considering those on both sides of the aisle?

i. Commissioner Koller: I think you are right that it is particularly applicable to habillitative, and I think if we hold off and wait till we get to that slide, you may see an answer to that question.

e. Dawn Wardyga: How we define that parity, how we define that word parity makes all the difference in the world. As you just described it, and if you relate it to the federal law on parity, versus allowing plans to offering up their own definition, I see that as two different things. I just need some clarification on that.

i. Lindsay McAllister: When we were considering what parity would mean in the future, we worked with Wakely to determine what that word would imply in different scenarios. And will walk through that in the coming slides.

f. Commissioner Koller: With Wakely, we gave them bundles of services and said please estimate the cost for these. They took a typical population and typical utilization – not RI specific. What we are looking at here is relative size. We are asking that you look at the relative differences rather than the absolute. They would likely come up with similar numbers but produce the same relative differences, but the important thing is the assumptions and consistencies, as opposed to getting it exactly right.

g. Mark Kerrin: Personally, I do not think I already had an insurance plan where I was limited to 20 visits. How common is that?

    i. Commissioner Koller: Well that is 20 visits for PT, OT and Speech, and for those areas it is common.
    ii. Commissioner Koller: We are talking about individuals here; if you want to see families, multiply it by 2.2.
h. Dawn Wardyga: If you say habillitative and you say 20 visits, I get nervous. So we assume for the purposes of the numbers on the screen, we limited to visits for PT, OT and Speech. And I know that you had to use something, but does that mean that when we talk about habillitative, for the most part have we made a decision?
    i. Lindsay McAllister: No, but as I think you can appreciate, in order to have any ideas around this, you need to have a straw man.
i. Elaina Goldstein: The autism and chiropractic are both benefits that are only offered in United, but are not offered as extensively in BCBS, so are they then not state mandated benefits?
    i. Commissioner Koller: Yes.
    ii. Elaina Goldstein: Could they offer a benefit beyond the benchmark plan then?
    iii. Commissioner Koller: Yes, there is a cost associated with it but they can do so.
    iv. Lindsay McAllister: The benchmark sets a floor.
j. Commissioner Koller: We do want to take a minute to say thank you to the plans for their assistance with all this as we look at the numbers and compare costs.
    i. Lindsay McAllister: We expected it would be close given our analysis of the lists of services, but the idea that they are between $1.00 and $1.25 apart is a bit leaner than we anticipated.
k. Elizabeth Lange: Pediatric vision is listed as limited by both plans, but the definition of limited is a bit different, so I am wondering if we can add in a parenthetical notation indicating that it changes from year to year.
    i. Lindsay McAllister: That is a good point and we can do that.
l. Commissioner Koller: Is the extra 75cents or dollar to get extra screening and for lenses a year a good value?
    i. Elizabeth Lange: I think that is the point, every child has teeth that needs to be seen twice a year, or eyes to be seen twice a year, but not every child has to have new lenses once a year. I think it should be covered maximally even if it will not be used maximally.
    ii. Multiple Individuals: Agreed, worth the extra dollar for this cause.
    iii. Elizabeth Lange: Also to the age point, I support the idea of age to 21 if possible, but definitely to 19.
    iv. Dawn Wardyga: As a parent if you are taking your child for an eye exam, but you do not have access to the lenses, I would

want to know if my child failed the exam because I couldn't fix it. I firmly believe we need to go with the higher coverage, understanding that not 100% of children will require that coverage, but there should be consistency.

m. Vivian Weissman: I would like us to go back to why we are doing this, which is to move from being a sick system to a health system. Because of the effects of vision, and later when we discuss dental, when we want to keep health at the forefront.
    i. Elaina Goldstein: The issue here, and this is where I think doing it this way is not a good way to do this, what is insurance and what is not insurance. To me, add this cost because it is important, and then saying we need to limit here and there, misses the point. You want this coverage to be for things you really cannot afford. There are glasses available at a lower cost. This is the issue I feel is the difference between Medicaid and insurance. We cannot have coverage for everything.
n. Elaine Jones: On the age issue, I know that at age 19 it is not that you do not have a doctor anymore… I think the age while important, it is less significant than some of the other things. That would be my point to that issue. The other complication with these other ages is not how they access the doctor, but how they pay for it.
o. Paul Block: I do just want to speak to the point that we are spending others money. I think it is hard to make decisions on items that are over what is affordable, and then adding 75 cents.
    i. Commissioner Koller: When you do a budget though, you frequently do not find a big item, it is usually a bunch of little.
p. John Peacock: Vision plans are underutilized. I probably have two groups that spend the money, they are limited to maybe 40.00 worth of lenses. It is an inexpensive benefit, but there are going to be some limits. Also the network, not all doctors' offices will be in that network.
    i. Lindsay McAllister: One of the challenges with dental and vision are that because they are essential health benefits, the use of dollar caps will not be permitted in the future.
    ii. Kim Holloway: I think it is important also that most of us do not have a vision network, but it would need to be developed.
q. Kathryn Shanley: Just a note on the pediatric dental supplementation slide, some numbers may vary.
    i. Lindsay McAllister: Yes.
r. Commissioner Koller: On dental, is there any reason that the decision for 19-21 should be different between pediatric vision and dental?
    i. Elaine Jones: I think there is a scientific issue, is there a difference in teeth between 19 and 21?
    ii. Kathryn Shanley: For the most part, in the commercial market the age is mostly 19. That is because dental is not covered in the ACA scope of coverage for those under 26 on family plans.

Now 13 on up the biggest cost is the removal of asymptomatic wisdom teeth. In terms of need there is no greater need for a 19 yr. old than a 21 year old. At that time you are primarily looking at cleanings and fillings.

iii. Lindsay McAllister: The way that a plan is typically designed is through classification of services?

iv. Kathryn Shanley: Pretty much preventative and diagnostic is covered at 100% of most commercial plants. Then when you get into class B it is not uncommon to see routine restorative work at 80%, and when you get into the more expensive it is 50%, and there are always annual maximums.

v. Commissioner Koller: We may try to understand the FED VIP benefit a bit more frankly to reduce that number, 525 to 750 numbers. If we do not have that latitude then it becomes something that the exchange and the plans have to look at. Do you try to reduce the overall benefit, or do you leave it to the benefit design column to improve affordability.

vi. Kathryn Shanley: If this were a child only dental plan, you would be talking more like 25-30 per month. It is a bigger number, and there is a usage.

s. Commissioner Koller: [Discussing the Habillitative Services Slide] It appears that the if you do not like the idea of the plans defining their own, then the only thing it appears the feds are giving the states are some sort of visit limit. There is discussion early if this is arbitrary or not clinically based, but it looks like the feds are saying it is too big to handle, let's just do parity. Nonetheless we have done numbers on something other than parity as well for a point of comparison. It does become a cost shift if you have something more than parity, less of a utilization of Medicaid and more of commercial, but not sure what that is.

t. Dawn Wardyga: When we look at the Medicaid regulations in the state and look at how services are provided for those who are lucky enough to be eligible for Medicaid (which I make not to be facetious, but in the pediatric world it is the only way kids can get what they need in the amount duration and scope that the need based on medical necessity is if they qualify for Medicaid). Access to Medicaid is not necessarily fair or equal, and if we have a child with a significant disability and we have access to jobs and commercial insurance but the kids cannot access Medicaid then they cannot access comprehensive insurance in this state. At some point in time these need to be spoken about in the same room. This is the one I lose sleep over, and that is because when you say parity we each can define it a different way. I understand the possibility or probability of cost shifting, but having said that I feel it is an important decision that we need to make, as we need to be concerned about unintended consequences on the other end.

u. Cathy Ciano: I couldn't agree more, and the way things work now is that parents are incentivized to stay below a poverty point so as not to loose the services provided by Medicaid, and that is a huge issue particularly around children's mental health services. I am glad it was brought up, it is a major issue that does impact a significant number of families across the state and around the country.
    i. Elaina Goldstein: I want to emphasize that we need to look at the adults as well.
v. Lindsay McAllister: Reaction to the four scenarios for habillitative services?
    i. Elaina Goldstein: The reason there is not a big difference is that there is a difference between habilitation and rehabilitation.
    ii. Commissioner Koller: We pushed the actuaries on scenario number 4, so I wouldn't hang our hats on that last number. And you would have to weigh the cost on number 4 with some of the savings, presumably there would be more savings on the Medicaid side and perhaps commercial enrollment. There may be a set of benefits that are very hard to quantify with a much more expansive definition.
    iii. Dawn Wardyga: Agree to the point that some of it is not quantifiable. These kinds of services are critical to keeping individuals stable and as healthy as possible, and cared for at home (another benefit that is not quantifiable). Having said that, when you think about the cost to take care of the same person within an institutional setting it is another decision. I find it hard to go forward with this discussion without protecting this population.
w. Mark Deion: The only thing I have here is that under a commercial situation there is no way that #1, #2, or #3 would do anything adequate to assist this population. Are they not then worthless? After hearing the recent advocates explaining this further, it seems the first three wouldn't make a difference if they do not do what they are supposed to do. Number 4 is a big black eye to everything else in the insurance industry, as we can say this is what Medicaid is spending, then we need to be able to do it.
    i. Elaina Goldstein: If they used our Medicaid data on this is that adults with disabilities want to work, but if they work then they cannot get the services they need to for that. So we have the Medicaid buy in. The global waiver has never been implemented correctly.
    ii. Gary Witman: I have the best commercial insurance that I can get, those 20 visits I am done with in six weeks. I pay thousands a year for coverage. And getting back to the comment about Medicaid, I cannot get the coverage they have offer there.

iii. Elaina Goldstein: I believe that if the commercial insurance would get involved I this, they I feel they would find better ways to get coverage, I firmly believe that.

x. Lindsay McAllister: So I am hearing a vote for the second approach? Defer to insurers?
   i. Elaina Goldstein: But you regulate the insurers.
   ii. Commissioner Koller: I think the fed came up with that option, let the insurers decide, as a means of letting the state people punt.
   iii. Bill Hollinshead: We have these ground rules that force us into this dilemma and is especially in RI politically powerful. What do we do to provoke a way to change the rules if we do not like the options from the ACA?
   iv. Mark Deion: Don't we have an option to appeal to HHS for another road? Looking at this or saying, give it over to the insurance companies, that doesn't seem….
   v. Commissioner Koller: Any of those solutions will result in higher premiums, at least on the short term, for employers, are we prepared to take on these social issues with that cost?
   vi. Mark Deion: If someone tells me I will spend 100 today, but will stem the cost in the long term, then I can deal with that, it is worthwhile. It is not bad to spend a bit more money to stem the rate of inflation.
   vii. Commissioner Koller: As much as we like, I don't think we can guarantee that.
   viii. Elaina Goldstein: I have data that shows that those on Medicaid buy in cost less than those on straight Medicaid.
   ix. Mark Deion: In all the work groups I participate in, some of the times we are asked to make decisions that are limited, and I always go to cost control and cost containment, and we make these limited decisions that ultimately the exchange is designed to reduce expenses. I am saying that there is a disconnect. Not saying I want to pay an additional 21.25 for a service with no guarantee, but what we are doing is making it more affordable.

y. Dawn Wardyga: When you talk about where guarantees may come from, you cannot do so because of so many unknowns. Again when the responsibility falls on a family to make sure this person gets the care they need. The whole concept behind health care reform is to keep us healthy and have equal coverage – get everyone in the pool so that when catastrophes happen there is money for coverage.

z. Kim Holloway: I recognize that this is a very important issue, but I am not sure that is the intent of the EHB is to fix this entirely. This is to be a package of benefits as a floor. My concern with #4 is that groups cannot handle a $5 increase on premiums, and adding on items like this is going to further create issues. I agree this needs to be

addresses, but I say take a step forward. But if we start increasing and add $20 here, it does not take into effect that other services will have limits and rate increases as well. It is more than $5 here or $5 there.

i. Elaina Goldstein: I just want to say this would be worse for people with disabilities, because what happens when someone gets in a freak accident, and he has this benefit, but he runs out of it. What happens, that is the concern by doing it this way. We haven't addressed it. Are you now prohibited from moving into Medicaid? Then you are worse off. That is the problem.
ii. Kim Holloway: If you hit 21 visits you are not cut off from coverage.
iii. Commissioner Koller: If there is a cliff between commercial and Medicaid, how does having more than 20 visits change this?
iv. Elaina Goldstein: If you need more benefits than in the private sector was is the movement into Medicaid. That is the question we have to answer in this development. If you tell me they can easily move into Medicaid they way they used to, then at least we haven't made anything worse.
v. Commissioner Koller: That is a conversation to be had with Medicaid.

aa. Kim Holloway: I say keep the floor at 19 for ages on pediatric and dental.
    i. Lindsay McAllister: Any drop from that? No? Okay we will move forward.

III. Public Comment: No additional comment made.
IV. Adjourn